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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **FERNANDO MORALES aka FERNANDO GINO MORALES** 808 Arden Ave. Glendale, CA 91202 Registered Nurse License No. 561684 Respondent.	Case No. 2010-299 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about January 18, 2000, the Board of Registered Nursing (Board) issued Registered Nurse License No. 561684 to Fernando Morales (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2011, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 118, subdivision (b), provides that the suspension, expiration, surrender or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

5. Section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2761 states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions. . . ."

7. Section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

REGULATORY PROVISIONS

8. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single

situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

COST RECOVERY

9. Section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

PATIENT A.C.

10. On or about April 13, 2006, at 23:00 (11:00 pm), Patient A.C., 23 years old, was a three (3) hour prior, new admittee to Aurora Las Encinas Hospital (ALEH), 2900 E. Del Mar Blvd., Pasadena, California, for treatment of addiction to Oxycodone[1] and Xanax[2]. ALEH provided inpatient detoxification (detox) treatment program and Respondent was the registered nurse on duty for 13 patients in the Briar unit where Patient A.C. was assigned.

11. On or about April 13, 2008, Respondent's shift began at 23:00 (11:00) and ended the next day at about 07:30 (7:30 am). At the beginning of his shift, Respondent received verbal instructions regarding Patient A.C. from the outgoing on duty registered nurse. Patient A.C.'s medical records note that he had unsteady vital signs, that his respiration was16 on admittance at 18:00 (6:00 pm), and 10, at 20:30 (8:30 pm); and that he had ingested a large quantity of opiates[3] and benzodiazapines[4] less than three (3) hours prior to admission. On April 13, 2008, at 23:00 (11:00 pm), a Withdrawal Assessment was performed indicating that Patient A.C. had, at most, none to mild withdrawal symptoms.

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[1] Oxycodone is a synthetic opioid analgesic commonly prescribed for acute and chronic pain. It is a potent opiate that can cause intense euphoria, relaxation, and sedation. Its analgesic properties are similar to those of morphine. The primary adverse (toxic) effect is respiratory depression, but others include apnea, respiratory arrest, circulatory depression, hypotension, and shock.

[2] Xanax, a brand name for alprazolam, is an anti-anxiety benzodiazepin.

[3] Opiates are any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having additions-forming or addiction-sustaining liability.

[4] Benzodiazapines are used to treat anxiety disorders and work in the brain to relax the mind and body.

12. On April 13, 2008, at 23:20 (11:20 pm), Respondent performed a Daily Assessment on Patient A.C. On April 14, at 07:00 (7:00 am), Respondent late charted his 23:20 assessment findings for Patient A.C. as: pain level of 0, patient "sedated and unsteady," vital signs within normal limits, respiration 12, and "slept without difficulty." Respondent failed to perform a thorough assessment of Patient A.C. at the beginning of this shift.

13. On or about April 13, 2008, at 23:30 (11:30 pm), Respondent performed a suicidal and anxiety risk assessment on Patient A.C. with recordings of: no suicidal ideation, anxiety – mild, and cravings to use – mild.

14. ALEH protocols require every 15 minute bed checks[5] on patients. As Respondent's support staff was unavailable or on break, he was required to perform the 15 minute bed checks from 02:45 (2:45 am) to 04:30 (4:30 am). During his shift, on April 14, 2008, Respondent performed three (3) 15 minute bed checks at 02:45, 03:00 and 03:45, and missed four (4) bed checks at 03:15, 03:30, 04:00, and 04:15 for Patient A.C.

15. On or about April 14, 2008, Respondent failed to check Patient A.C. at least every two (2) hours, noting his breathing pattern and level of consciousness.

16. On April 14, 2008, at 07:00 (7:00 am), a half hour before his shift was over, Respondent was late charting medical records for Patient A.C.

17. On April 14, 2008, at about 07:15 (7:15 am), the oncoming shift's mental health worker performed the 15 minute bed checks and found Patient A.C. unresponsive. A Code Blue[6] was called.

18. On or about April 14, 2008, at 7;45 am, patient A.C. was pronounced dead. (Pasadena Police Department Injury and Death Report records that paramedics pronounced patient A.C.'s time of death and initiated Coroner Case No. 2008-02879.)

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[5] The 15 minute checks require staff to enter the patient's room, use a flashlight to see breathing movement of the body and listen to the patient's breathing pattern. The medication nurse (LVN) or mental health worker perform the 15 minute checks during the shifts. The RN performs the checks when either are on break.

[6] Code Blue refers to the broadcast alert and procedures for responding to a medical emergency in the hospital, bringing qualified personnel and equipment to the location of the emergency.

CAUSE FOR DISCIPLINE

(Gross Negligence)

19. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in conjunction with California Code of Regulations, title 16, section 1442, in that on or about April 13 – 14, 2008, Respondent was grossly negligent in the care of Patient A.C. when he failed to complete an initial and ongoing patient assessment consistent with a patient who was under the influence of controlled substances, a patient who had received central nervous system (CNS) depressants from the nurse on the prior shift, and a patient who was being assessed for withdrawal from substance abuse. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 10 - 18, inclusive, as though set forth fully.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License No. 561684, issued to Respondent;

2. Ordering Respondent to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 12/16/09

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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